SOUTH CAROLINA BUDGET & CONTROL BOARD
EMPLOYEE INSURANCE PROGRAM
MoneyPlu$ ENROLLMENT FORM

Plan Year:

You must complete this form if you wish to start or continue a tax-free Medical Spending and/or Dependent Care Account.

Press hard with black ballpoint pen.

Group Number	Employer (Name of State Group/Entity)

Name (Please Print) Last	First	MI	Social Security #

Home Address Street	City	State	Zip

Daytime Phone ( )	Home Phone ( )	Date of Hire	Date of Birth	Annual Salary

ENROLLMENT STATUS ☐ RE-ENROLLMENT ☐ NEW HIRE

Indicate the amount you wish to pay through tax-free salary deduction by completing the sections below.
If you have questions, consult your Enrollment Counselor, worksite administrator or employer.

In Box #1 indicate the dollar amount you elect to contribute for the upcoming plan year.
In Box #2 indicate the number of regular payroll checks you will receive during the upcoming plan year.
In Box #3 indicate the reduction amount per paycheck. (Note: If Box #2 times Box #3 does not equal box #1 exactly, the amount in Box #3 may be changed slightly by FBMC due to rounding).
By signing this form you certify that you expect to receive the number of paychecks listed in Box #2 unless the early retirement/termination box is selected.

MEDICAL SPENDING ACCOUNT

For eligible medical expenses incurred by you, your family members, or both.
[Maximum allowable contribution is $5,000 annually.)

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks _____

Box #3
Reduction per regular paycheck _____

Your payroll center will automatically deduct the appropriate fees in addition to the above amounts.

DEPENDENT CARE ACCOUNT

TAX FILING STATUS (Please check one):

☐ Married, filing separately [maximum - $2,500]
☐ Married, filing jointly [maximum - $5,000]
☐ Single, head of household [maximum - $5,000]

Box #1
Total plan year dollar amount from your worksheet _____

Box #2
Number of regular paychecks _____

Box #3
Reduction per regular paycheck _____

Your payroll center will automatically deduct the appropriate fees in addition to the above amounts.

☐ I plan to retire or terminate my employment prior to December 31. I wish to have my full amount withheld from my first _____ paychecks. The number should be less than box #2. I understand that the funds in any FSA can only be paid out to reimburse payment of eligible expenses actually incurred during my period of coverage.

IMPORTANT

- I hereby authorize my employer to reduce my gross salary before federal taxes are calculated by the total amount of annual salary deduction indicated above.
- I understand that any amount remaining in any FSA not used during this plan year will be forfeited since it cannot be carried forward to the next plan year.
- I understand that the funds in one FSA cannot be used to reimburse expenses covered by another FSA.
- I understand that expenses for which I am reimbursed cannot be deducted on my income tax return.
- I understand that the amount of salary deduction will include the items specified above and will continue in effect unless I terminate employment or file an approved family status change with the contract administrator within 31 days of the event or before the end of the plan year.
- I understand and agree that my employer and Fringe Benefits Management Company, the contract administrator, will not incur any liability resulting from either my participation in any FSA or my failure to sign or accurately complete this enrollment form. I further understand that if I elect not to participate in salary deduction with respect to the benefits listed above, I hereby forego my right to participate during the upcoming plan year.
- I certify that: 1) I will only use my FSA to pay for IRS-qualified expenses and only for my IRS-eligible dependents, 2) I will exhaust all other sources of reimbursement, including those provided under my Employer's plans before seeking reimbursement from my FSA, 3) I will not seek reimbursement through any other source, and 4) I will collect and maintain sufficient documentation to validate the foregoing.

EMPLOYEE SIGNATURE	Date Signed

For eligibility purposes, for the Medical FSA, I certify that this employee is a full time, permanent employee with one year's eligible service as of January 1 in the plan year in which the employee is enrolling. EMPLOYER/ BENEFITS ADMINISTRATOR	Date Signed

FOR OFFICE USE ONLY:

Payroll Center _____ Payroll Frequency _____

FBMC USE ONLY

DATA ENTRY	VERIFICATION	SCANNED	INDEXED	SPECIAL NOTES

EFFECTIVE DATE OF COVERAGE	PAYROLL DATE

FBMC
Fringe Benefits Management Company

EMPLOYEES: SUBMIT YOUR COMPLETED FORM to YOUR BENEFIT ADMINISTRATOR.
BENEFIT ADMINISTRATORS: Send signed form to: Enrollment Processing P.O. Box 1878 Tallahassee, FL 32302-1878